Effective Date: 10/30/18

Note: *If you have a disability that requires this material to be produced in an alternate format, please contact the City's ADA Program Manager at (808) 768-8599 or via email at:* mona.higa@honolulu.gov. *Please allow a minimum of five (5) business days for your request to be processed.*

ADA TITLE II COMPLAINT

City & County of Honolulu

Equal Opportunity Office

COMPLAINANT INFORMATION

Name of Complainant: _____

_____ I am a person with a disability

_____ I am filing a complaint on behalf of a person with a disability

Address: _____

City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

Preferred Method of Contact: _____

COMPLAINT INFORMATION (Attach additional pages if necessary)

Department/Agency (if known):_____

Fill out as applicable:

Date of incident: _____

Where did the incident take place? _____

Name of alleged offender (if known): _____

Describe the incident, issue or alleged act of discrimination or retaliation in as much detail as possible.

_____

_____

_____

_____

_____

ATTEMPT AT RESOLUTION (Attach additional pages if necessary)

Was an attempt made to directly resolve this issue with the responsible Department/Agency?

____ No ____ Yes; if yes, provide date and relevant details below:

Name of Department/Agency Contact (if known): _____

Response or action taken by the Department/Agency (if known):

_____

_____

_____

_____

ADDITIONAL INFORMATION THAT MAY BE RELEVANT FOR CONSIDERATION AND RESOLUTION OF THE COMPLAINT (Attach additional pages if necessary)

_____

_____

_____

_____

_____

_____

_____ _____

SIGNATURE OF COMPLAINANT **DATE**